Sharing Information Across Physical and Behavioral Health: Debunking Myths, Developing Strategies

Thursday, August 6th, 2015

2:30 - 4:00pm ET

For audio, please listen through your speakers or call:

1-844-302-6774, conference ID # 86279518

Supported by the Commonwealth Fund

Agenda

2:30 – 2:40 pm	**Welcome and Introductions** • Kitty Purington*, NASHP*
2:40 – 3:00 pm	**Overview** • Karla Lopez, *Legal Action Center*
3:00 - 3:40 pm	**Sharing Information Across Physical and Behavioral Health: Strategies from North Carolina and New York** • Amelia Mahan, *Community Care of North Carolina* • Greg Allen, *New York State Department of Health*
3:40 - 4:00 pm	**Questions and Answers** • Kitty Purington*, NASHP*

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SHARING INFORMATION ACROSS PHYSICAL & BEHAVIORAL HEALTH

Presented by Karla Lopez of Legal Action Center

Aug. 6, 2015

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Background

- The confidentiality of health information is protected by a combination of federal and state law
- Federal laws protect:
  - All health info (HIPAA)
  - Substance use disorder info (42 CFR Part 2)
- State law varies, but often protects the following types of information:
  - Mental health
  - HIV/AIDS
  - Reproductive health

Federal Laws

Two federal laws apply to behavioral health information:

- (1) HIPAA
  - Applies to most health care providers and insurers
  - Applies to all types of health information
  - Federal "floor" of confidentiality

- (2) 42 CFR Part 2
  - Applies to substance use disorder ("SUD") prevention/ treatment providers
  - Applies to information that identifies someone as having SUD
  - Older and stricter than HIPAA

Federal Laws

HIPAA

- HIPAA allows health information to be disclosed without patient's consent for:
  - Treatment (e.g., to other health care providers);
  - Payment (e.g., to health insurer); and
  - Health care operations (e.g., administration of health care provider's business)
- Learn more about treatment, payment, and health care operations disclosures:

  http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html

Federal Laws

HIPAA, cont'd….

- HIPAA does not, for the most part, treat behavioral health information differently from other health information
- Psychotherapy notes are more protected, but defined narrowly
- Learn more about sharing mental health info under HIPAA: http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html

Federal Laws

42 CFR Part 2

- Substance use disorders carry potential negative consequences that are unique within the health care system
  - Criminal
  - Employment
  - Child custody

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Federal Laws

42 CFR Part 2, cont'd….

- These negative consequences often deter people from seeking treatment for SUD
- To address this problem, in the 1970s Congress passed federal confidentiality law for alcohol & drug treatment & prevention records—known as 42 CFR Part 2

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Federal Laws

42 CFR Part 2, cont'd….

- 42 CFR Part 2 is usually more protective of patient privacy than HIPAA
- Only applies to SUD treatment/prevention providers:
  - "federally funded"
  - Hold themselves out as providing, and do provide, alcohol or drug abuse diagnosis, treatment, referral to treatment or prevention
- Can apply to an individual or an organization
- Does not apply to general medical facilities (but can apply to a unit or individual in such a facility)

Federal Laws

42 CFR Part 2, cont'd….

- Whereas HIPAA allows disclosures of general health information without patient consent for treatment, payment, or health care operations,

- SUD information protected by 42 CFR Part 2 can be disclosed only in certain circumstances……

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42 CFR Part 2

Permitted Disclosures

- Internal Communications
- No patient identifying information
- Proper Consent
- Qualified Service Organization/ Business Associate Agreement
- Medical Emergency
- Reporting suspected child abuse and neglect
- Court Order
- Research/ Audit
- Crime on program premises or against program personnel

State Laws

State Laws

- Whereas federal laws (HIPAA and 42 CFR Part 2) apply to all 50 states, states may also pass their own confidentiality laws, and these vary around the country
- Why do states pass confidentiality laws of their own?
  - Usually, to protect sensitive health information, like mental health, HIV/AIDS, and reproductive health
- What to do when multiple laws apply?
  - Follow the most stringent (most privacy protective) law
- How to find out if your state has its own confidentiality law(s)?
  - Work with your agency's privacy officer
  - Your state attorney general's office may also have resources

Federal & State Laws: Recap

Recap

- Confidentiality of health and behavioral health information is protected by 2 federal laws
  - HIPAA applies to all types of health care information
  - 42 CFR Part 2 applies to SUD information
- States also have their own confidentiality laws, often including state laws governing the confidentiality of mental health information

Confidentiality Laws & Integrated Care

How can behavioral health information be included in integrated care settings?

- Under HIPAA (all health information):
  - If for treatment, payment, or health care operations, no patient consent needed—can generally exchange freely
- Under 42 CFR Part 2 (SUD information):
  - Patient Consent
  - Qualified Service Organization Agreement (like a Business Associate Agreement under HIPAA)
  - Medical emergency exception
  - *Within the SUD program*: internal communications exception
  - **Note**: Prohibition on Redisclosure for first two
- Be sure to find out whether your state has any additional confidentiality laws

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Myths & Facts

- **Myth**: Behavioral health information cannot be included in electronic health information exchange (HIE)
- **Fact**: It can be included, as long as the HIE has policies & procedures in place that comply with confidentiality laws.
  - HIPAA: If only exchanging information for treatment, payment, and health care operations, no patient consent needed
  - 42 CFR Part 2: Include SUD information by getting patient consent or by setting up a Qualified Service Organization Agreement. Some things HIE should consider:
    - Prohibition on Redisclosure
    - Consent (e.g., expiration, revocation, "to whom")
    - No access by law enforcement
  - State laws
- **Model**: Consent 2 Share
  - http://wiki.siframework.org/SAMHSA+Consent2Share+Project

Myths & Facts

- **Myth**: Patients' SUD information cannot be exchanged between physical & behavioral health care providers
- **Fact**: Information can be exchanged, staying mindful of confidentiality laws….
  - Physical health → SUD: No consent required by HIPAA if disclosure is for treatment purposes
  - SUD → Physical health: 42 CFR Part 2 allows disclosure in various circumstances, such as:
    - Patient consents (in writing)
    - Qualified Service Organization Agreement in place
    - Medical emergency
  - Mental health: check state laws

Myths & Facts

- **Myth**: If we provide SBIRT services, we will have to comply with that burdensome SUD confidentiality law (42 CFR Part 2)
- **Fact**: SBIRT services are only covered by 42 CFR Part 2 when they are conducted by providers who are already covered by 42 CFR Part 2 (i.e., alcohol/drug treatment/prevention providers)
- For more info, see Q. 11 of SAMHSA FAQs: http://lac.org/wp-content/uploads/2014/12/SAMHSA_42CFRPART2FAQII_Revised.pdf

42 CFR Part 2: Upcoming Changes?

- Last summer, SAMHSA held a Listening Session about the possibility of making changes to 42 CFR Part 2
- Additional guidance from SAMHSA on how to exchange & integrate SUD information is expected soon, possibly in the form of changes to the law
- Read Legal Action Center's comments on proposed changes to 42 CFR Part 2 here: http://lac.org/wp-content/uploads/2014/12/LAC_COMMENTS.pdf

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Learn More

- Legal Action Center's SUD confidentiality resources: http://lac.org/resources/substance-use-resources/confidentiality-resources/
  - Webinars
  - SAMHSA FAQs
  - Sample forms

- More info on HIPAA Privacy Rule: http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/index.html
- Legal Action Center hotlines to answer questions about alcohol/drug confidentiality (42 CFR Part 2):
  - Free hotline for New York providers
  - Subscription hotline for other states (Actionline): http://lac.org/wp-content/uploads/2014/12/New_Actionline_Flyer.pdf

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THANK YOU!

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SHARING INFORMATION ACROSS PHYSICAL AND BEHAVIORAL HEALTH: DEBUNKING MYTHS, DEVELOPING STRATEGIES – COMMUNITY CARE OF NORTH CAROLINA (CCNC)

August, 6, 2015

Amelia Mahan MSW, LCSW
Director, Behavioral Health Integration
CCNC
amahan@n3cn.org

CCNC as Medicaid Contractor

- Primary Care Case Management System (PCCM) for NC Medicaid
- The PCCM program is carried out chiefly through:
  - (a) the development and support of primary care medical homes;
  - (b) a data-driven, statewide care management program.

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Primary Goals of CCNC

- Improved care of the enrolled Medicaid population while controlling costs
- A “medical home” for patients, emphasizing primary care
- Community networks capable of managing recipient care
- Local systems that improve management of chronic illness in both rural and urban settings

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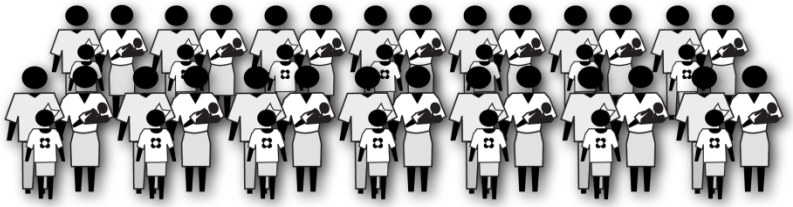
CCNC Footprint Statewide

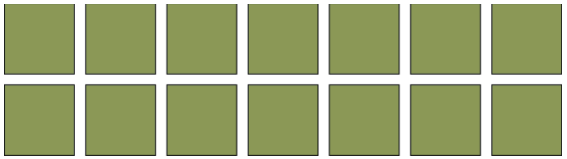
- 6,000 primary care providers (medical homes)
- 90% of PCPs in NC



- 1.4 million Medicaid Patients
- 300,000 Aged, Blind, Disabled
- 150,000 Dually Eligible

All 100 NC Counties

14 Networks



- **Build & support medical homes**
- **Provide care management**
- **Each network averages:**
  - 1.4 Medical Directors
  - 42.8 Local Care Managers
  - 1.8 Pharmacists
  - 1.0 Psychiatrist

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Behavioral Health Initiative and Community Care

- Added in 2010, with a focus on:
  - Treating the “whole patient”
  - Breaking down “Silos” of care
  - Improving health outcomes

*** Not meant to replace Specialty Behavioral Health

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NC Medicaid Statistics of People with Mental Health (MH) conditions

- 20% of Medicaid eligibles are diagnosed with a Mental Health (MH) condition
- 80% of patients diagnosed with MH are enrolled in a CCNC medical home/primary care practice
- 52% of patients currently actively care managed by CCNC are diagnosed with a MH condition
- 75% of people with a MH condition have another chronic health condition (hypertension, diabetes)
- 35% of people with a MH condition have 3 or more chronic health conditions

·Excluding IDD or Autism only

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Two different, but related, populations that we serve:

- Individuals with behavioral health needs that can be treated within primary care setting (i.e. mild to moderate depression, anxiety, etc.)
  - Focus – patient engagement, self-management, screening as needed, supporting primary care

- Individuals with Serious and Persistent Mental Illness (SPMI) that also have comorbid chronic physical health needs (i.e. schizophrenia and uncontrolled diabetes)
  - Focus – communication between medical and behavioral health providers and systems

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Successful Communication Strategies

- **Relationship building:**
  - Clarifying language and reasonable expectations – Primary Care and Behavioral Health Providers are different!
  - Creating opportunities to meet
- **Strong referral and feedback pathways:**
  - Anticipating need and proactively developing
  - Full integration is the ideal. Effective collaboration should be the norm.
- **Shared data and documentation**

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Community Care of North Carolina

Behavioral Health Provider Collaboration Primer

Table of Contents

For BH Providers: Practical ways to work Primary Care

- Gain consent upon intake for release of information to Primary Care for all patients
  - Should be part of agency culture that coordination will happen as a part of better health
- Collaborate and share care as needed
  - Close referral loop, share diagnosis, treatment approach, prognosis, labs, medications, etc.
- Share your specialty strengths – market yourself
- Improve skillsets and assessment with prevalent physical health conditions
  - Diabetes, Chronic Pain, Hypertension, Diabetes/ Depression groups, etc.

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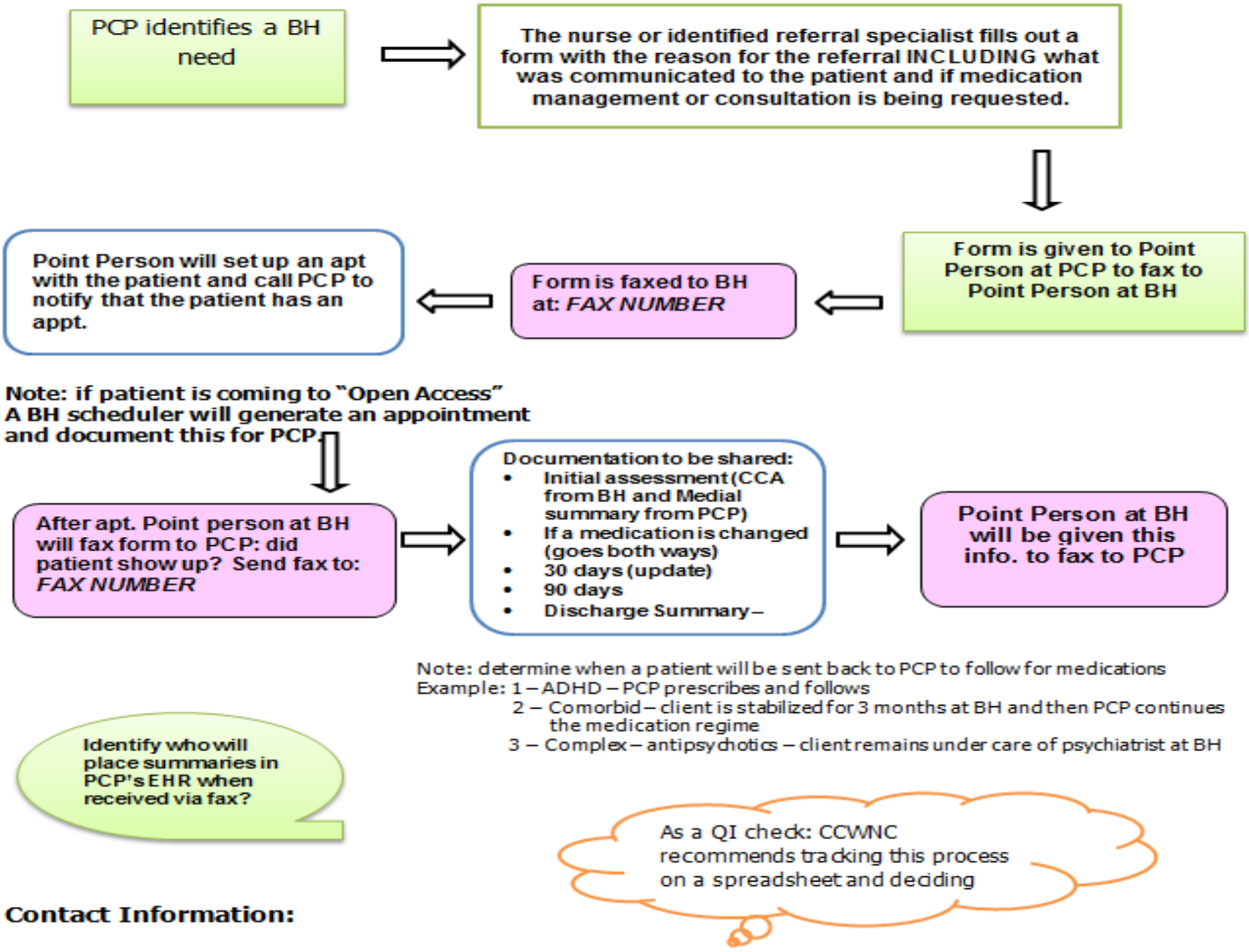
REFERRAL PROCESS FROM PRIMARY CARE (PCP) TO BEHAVIORAL HEALTH (BH)



Contact Information:

Referral Forms:

- Form #1 – Behavioral Health Request for Information – this form is for behavioral health providers who begin working with a new consumer or identify a potential medical need, and wish to make contact with the PCP.

- Form #2 – Referral to Behavioral Health Services Section I – this form is for PCPs to make a direct referral to a behavioral health provider for an assessment and/or services.

- Form #3 – Behavioral Health Feedback to Primary Care Section II – this form is to be used in conjunction with the 2nd form listed above. It is for behavioral health providers to complete and send back to the PCP after receiving a referral.

https://www.communitycarenc.org/population-management/behavioral-health-page/referral-forms/

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Behavioral Health Provider Partnership (BHPP) – History

- Pilot project began in Fall 2011 at the state level to explore possibilities of creating the first CCNC specialty network
- Goals:
  - Use of data to promote and enhance integrated physical and behavioral health care for Medicaid recipients
  - Create clinical pathways that improve patient care
  - Explore alternative payment methodologies to allow behavioral health and other specialty providers to move towards value-based care

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Direct Access to Informatics

- **CCNC's Provider Portal** – secure portal that allows access to care team summary, visit history, medications, labs, etc. on a patient by patient basis
- **Patient List Report** – report showing a list of all patients connected with the CABHA
  - Can be filtered by CABHA site
- **Current Hospital Visit Report** – based on real-time Admission, Discharge, and Transfer (ADT) information
  - Indicates priority indicators, outpatient follow-up recommendations
- **Narcotic Utilization Report** – shows opioid, benzo, and hypnotic fills in the past year

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Provider Portal

Welcome: Annette Dubard

Logout | Feedback | Support | Links | Survey | My Profile

Medicaid ID [redacted] Search

Last Name Exact Birth Date mm/dd/yyyy Clear All

Last Name Partial First Name Partial Birth Year yyyy

Home | Patient List | Patient Profile | Report Site | Meducation ® | Pt. Education

Care Team | Medications | Visit History | Communications (0) | Linked Sites

Patient: [redacted]		Medicaid ID: [redacted]	Gender: Female	Birth Date: [redacted]	Age: 42
Address [redacted]			County: [redacted]	Phone 1: [redacted]	Phone 2: [redacted]
Months Medicaid-Eligible: 12	Medicaid: Yes	Medicare: No	HealthChoice: No	Other Insurance: No	Program Code: MADC

Carolina Access PCP: UNC Internal Medicine (UNC P&A)	Phone: (919) 966-6989	Fax: (919) 966-6627
Carolina Access PCP Address: 101 MANNING DR, CHAPEL HILL, NC 27514-4220		PCP County: ORANGE

Care Alerts: 5	Recent Hospital Use: 9	Inpatient Visits *: 6	Hospital Observation Stays *: 0
ED Visits *: 10	Imaging *: 26	Office Visits */Visits toward Limit: 14 / 8	Outpatient Behavioral Health *: 1
ST/PT/OT *: 0	Lab Values *: 99	DME Supplies *: 0	Medication Fills / History: 25 / 93
Pain Agreements: 0	Advance Directives: 0	Other Pt. Documents: 0	Medicaid Cost per Month: $ 5,230.16
Immunizations: 0			

* Based on 15 months of data.

Care Coordination

Print Care Team | Print Patient Profile

Resources:

CCNC Network: AccessCare			Phone: (877) 570-0001	Fax: (919) 468-8573
Primary Care Mngr.: Kimberly Glass	Care Mngmt. Status: Medium	Last Contact: 11/27/2012	Phone: (336) 264-8945	Fax:
Network Pharmacist: Gretchen Tong			Phone: (919) 843-4423	Fax: (919) 843-6544
Mental Health Local Management Entity (LME): Alamance-Caswell LME			Phone: (888) 543-1444	
CABHA: PSYCHOTHERAPEUTIC SERVICES INC	Address: 1159 HUFFMAN MILL ROAD BURLINGTON, NC 272158862			County: ALAMANCE

Care Team | Medications | Visit History | Communications (0) | Linked Sites

Patient: [redacted] | Medicaid ID: [redacted] | Birth Date: [redacted] | CA PCP: [redacted]

Allergies: [redacted] | **Adverse Reactions/Intolerance:** Not Evaluated

Medicaid Claims Paid Through: 11/21/2012 Medicaid Claims Fill Date Through: 11/15/2012

Consolidated Medication List | Meducation | North Carolina Drugs of Choice Information

Prescription Fill History (•) Current Regimen ( ) Complete History

Options: Print Regimen | Print Pocket Med List

Fill Date	Drug Description	Qty	Days	Paid	Class	DOC	Gap	AI	Prescriber	Pharmacy	Source
11/14/12	HYDROMORPHON TAB 2MG	5	1	$0	ANALGESICS, ...				ALPHEUS BENJ ...	MEDICAL VILL ...	MNC (18)
11/09/12	SOFTCLIX MIS LANCETS	100	50	$11	MEDICAL SUPP ...				CHAITANYA M ...	MEDICAL VILL ...	MNC (1)
11/01/12	NEXIUM CAP 40MG	30	30	$200	ANTI-ULCER/O ...				JANINE L THE ...	MEDICAL VILL ...	MNC (42)
11/01/12	ACCU-CHEK TES AVIVA PL	50	18	$29	DIAGNOSTICS				EDWARD L BAR ...	MEDICAL VILL ...	MNC (1)
10/25/12	PROMETHAZINE TAB 25MG	60	15	$5	ANTIHISTAMIN ...	✓			TANVIR REZWA ...	MEDICAL VILL ...	MNC (10)
10/25/12	TRAZODONE TAB 100MG	30	30	$8	PSYCHOSTIMUL ...	✓		1 Fill	MOHAMMAD FAH ...	MEDICAL VILL ...	MNC (11)
10/25/12	TRAMADOL HCL TAB 50MG	80	10	$9	ANALGESICS, ...	✓			GARRETT DOUG ...	MEDICAL VILL ...	MNC (40)
10/23/12	QUETIAPINE TAB 300MG	30	30	$35	ANARACTICS - ...			0.78	MOHAMMAD FAH ...	MEDICAL VILL ...	MNC (38)
10/19/12	CYMBALTA CAP 30MG	30	30	$193	PSYCHOSTIMUL ...		10	1.02	GARRETT DOUG ...	MEDICAL VILL ...	MNC (44)
10/08/12	NOVOLIN INJ 70/30	10	25	$76	DIABETIC THE ...				CHAITANYA M ...	MEDICAL VILL ...	MNC
10/05/12	HYDROCO/APAP TAB 5-325MG	50	6	$14	ANALGESICS, ...	✓			MARY ANN COL ...	MEDICAL VILL ...	MNC (7)
9/18/12	LITHIUM CARB CAP 300MG	60	30	$8	PSYCHOSTIMUL ...		41*	0.99	MOHAMMAD FAH ...	MEDICAL VILL ...	MNC (11)
9/06/12	INSULIN SYRG MIS 0.5/31G	100	50	$28	MEDICAL SUPP ...				CHAITANYA M ...	MEDICAL VILL ...	MNC (1)
8/28/12	METFORMIN TAB 500MG	60	30	$0	DIABETIC THE ...	✓	62*	1.12	GARRETT DOUG ...	MEDICAL VILL ...	MNC (18)
8/28/12	NYAMYC POW 100000	30	10	$28	FUNGICIDES				GARRETT DOUG ...	MEDICAL VILL ...	MNC (19)
8/28/12	VALACYCLOVIR TAB 1GM	11	6	$55	ANTIVIRALS				GARRETT DOUG ...	MEDICAL VILL ...	MNC (9)
8/27/12	PEN NEEDLES MIS 29GX1/2"	100	50	$14	MEDICAL SUPP ...				GARRETT DOUG ...	MEDICAL VILL ...	MNC (1)
8/27/12	HUMULIN N PN INJ U-100	15	34	$238	DIABETIC THE ...				GARRETT DOUG ...	MEDICAL VILL ...	MNC (2)
8/18/12	METRONIDAZOL TAB 500MG	14	7	$9	ANTIPARASITI ...	✓			JEANETTE ELI ...	MEDICAL VILL ...	MNC
8/18/12	KLOR-CON M20 TAB 20MEQ ER	5	5	$8	ELECTROLYTES ...				JEANETTE ELI ...	MEDICAL VILL ...	MNC
8/16/12	FLUCONAZOLE TAB 150MG	1	1	$6	FUNGICIDES	✓			SHAILI NIRAN ...	MEDICAL VILL ...	MNC (1)
8/10/12	OXYCOD/APAP TAB 5-325MG	60	15	$10	ANALGESICS, ...	✓			SHAILI NIRAN ...	MEDICAL VILL ...	MNC (12)
8/01/12	HYDROCHLOROT TAB 25MG	30	30	$6	DIURETICS	✓	89*	0.81	JANINE L THE ...	MEDICAL VILL ...	MNC (10)
3/19/12	FLUOXETINE CAP 20MG	30	30	$2	PSYCHOSTIMUL ...	✓	224*	0.47	PHILIP H. LA ...	MEDICAL VILL ...	MNC (1)
3/19/12	DIVALPROEX TAB 250MG DR	180	30	$24	ANTICONVULSA ...	✓	224*	0.47	PHILIP H. LA ...	MEDICAL VILL ...	MNC (4)

Recent Hospital Use - 9

This section displays visits within the past 90 days, updated twice daily from participating hospitals. Click here for list of participating hospitals. Visit information may be duplicated in the ED Visits and Inpatient Visit sections, which are generated after claims payment.

Visit Type	Admit Date	Discharge Date	Diagnosis 1	Diagnosis 2	Facility
Inpatient	11/26/2012	11/27/2012			University of North Carolina Hospital - Chapel Hill
ED	11/25/2012	11/26/2012	ABD AND BACK PAIN FEVER N V	DM2/NOS UNCOMP NSU	Alamance Regional Medical Center
Inpatient	11/17/2012	11/19/2012			University of North Carolina Hospital - Chapel Hill
ED	11/13/2012	11/13/2012			University of North Carolina Hospital - Chapel Hill
Inpatient	11/6/2012	11/9/2012	SEROMA COMPLICATING PX	REGIONAL ENTERITIS NOS	University of North Carolina Hospital - Chapel Hill
ED	11/6/2012	11/6/2012	EMS RM FLEX 6 ABD PAIN		Alamance Regional Medical Center
Inpatient	9/22/2012	10/5/2012	OBSTR INCISIONAL HERNIA	AC RESP FAIL TRAUM/SURG	University of North Carolina Hospital - Chapel Hill
Inpatient	9/9/2012	9/11/2012			University of North Carolina Hospital - Chapel Hill
ED	9/9/2012	9/9/2012	BACK AND ABD PAIN		Alamance Regional Medical Center

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Inpatient Visits - 6

Admit Date	Discharge Date	Diagnosis 1	Diagnosis 2	Diagnosis 3	Facility
9/22/2012	10/5/2012	OBSTR INCISIONAL HERNIA	ACUTE RESPIRATORY FAILURE FOLLOWING TRAUMA AND SURGERY	OLIGURIA & ANURIA	UNC HOSPITALS
9/9/2012	9/11/2012	URIN TRACT INFECTION NOS	REGIONAL ENTERITIS NOS	BIPOLAR DISORDER UNSPECIFIED	UNC HOSPITALS
8/21/2012	8/27/2012	DIABETES MELLITIS W/O COMPLICATION, TYPE II, UNCONTROLLED	NONHEALING SURGICAL WOUND	HYPOSMOLALITY	UNC HOSPITALS
1/19/2012	1/21/2012	ABDOMINAL PAIN, OTHER SPEC. SITE	REG ENTERITIS, SM INTEST	ANEMIA OF OTHER CHRONIC DISEASE	UNC HOSPITALS
9/7/2011	9/30/2011	PERSIST POSTOP FISTULA	INTESTINAL FISTULA	REGIONAL ENTERITIS NOS	UNC HOSPITALS
9/5/2011	9/7/2011	REGIONAL ENTERITIS NOS	BIPOL AFF, MIXED-UNSPEC	ANAL FISTULA	ALAMANCE REGIONAL MEDICAL CENTER

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Emergency Department Visits - 10

Admit Date	Admit Day	Admit Hour	Primary Diagnosis	Secondary Diagnosis	Facility
11/6/2012	Tuesday		ABDOMINAL PAIN, UNSP. SITE	HYPERTENSION NOS	ALAMANCE REGIONAL MEDICAL CENTER
9/9/2012	Sunday		URIN TRACT INFECTION NOS	TOBACCO ABUSE-IN REMISS	ALAMANCE REGIONAL MEDICAL CENTER
8/17/2012	Friday		OTHER CHRONIC PAIN	ABDOMINAL PAIN, UNSP. SITE	ALAMANCE REGIONAL MEDICAL CENTER
6/26/2012	Tuesday		REGIONAL ENTERITIS NOS	HYPERTENSION NOS	UNC HOSPITALS
5/29/2012	Tuesday		OTHER CHRONIC PAIN	ABDOMINAL PAIN, UNSP. SITE	ALAMANCE REGIONAL MEDICAL CENTER
3/19/2012	Monday		ABDOMINAL PAIN, UNSP. SITE	HISTORY TOBACCO USE	ALAMANCE REGIONAL MEDICAL CENTER

Expansion – Local BHPPs!

- Successful local pilot led to the initiation of BHPPs in six additional CCNC networks.
  - Collaboratives focus on populations in one county or in one region
  - Identify specific project or projects that address aspects of the Triple Aim: improving experience of care, improving health of populations, reducing costs
  - A small team of designated individuals including: someone in a position of leadership or who is well-connected with leadership, someone well-versed in QI, someone who interfaces with patients
  - IT capability to upload MIDs, access reports, etc.

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Key Points

- Eliminate real and perceived barriers to sharing information for treatment, care coordination, and quality improvement
  - Education campaign: sharing information for these purposes is a part of better coordinated healthcare
- Utilize health information exchanges and population health analytics to create shared data systems
- Build relationships!

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SHARING HEALTH INFORMATION ACROSS SYSTEMS

New York State Department of Health
Office of Health Insurance Programs

Greg Allen, Policy Director

August 6, 2015

Agenda

1. **Current Challenges in Sharing Information Across Systems**
2. **DSRIP & Performing Provider Systems (PPSs)**
3. **Data Access in DSRIP**
4. **Patient Consent and Data Security**
5. **Open Discussion**

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Current Challenges in Sharing Information Across Systems

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Challenges in Sharing Data Across Systems

1. In some cases, there is no existing legal relationship between providers that requires them to share data

2. Patient consent is required to share data across providers of separate health systems, both related to sharing, accessing, or conduct analysis

3. Health technologies need to be adapted to allow for seamless interoperability

4. Consistent Data standards and data governance need to be standardized across providers in the system to optimize usability, accuracy, and integrity of the data

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Policy Standards to Consider When Structuring Data Integration

Policy Standards	Description
Participation Agreement	Require participants to comply with exchange Policy Standards
Consent Management	Ability to track the patient has given express consent to access clinical Protected Health Information; exceptions apply
Authorization	Process for determining whether a particular individual within a Participant has the right to access Protected Health Information via the exchange
Authentication	Verifying that an individual who has been authorized and is seeking to access information via the exchange is who he/she claims to be
Access	Access controls govern when and how a patient's information may be accessed by Authorized Users
Audit	Oversight tools for recording and examining access to information and are necessary for verifying access controls
Breach	Minimum standards Entities and Participants will follow in the event of a breach

DSRIP & Performing Provider Systems (PPSs)

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2014 MRT Waiver Amendment

- Medicaid Redesign Team (MRT) convened January 2011 to develop an action plan to reshape the Medicaid system to reduce avoidable costs and improve quality
- In April 2014, Governor Andrew M. Cuomo announced that New York State and CMS finalized agreement on MRT Waiver Amendment
- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York's health care delivery system

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DSRIP Explained

- Short for: "**D**elivery **S**ystem **R**eform **I**ncentive **P**ayment" Program
- Overarching goal is to reduce avoidable hospital use – ED and inpatient– by 25% over 5+ years of DSRIP
- This will be done by **developing integrated delivery systems**, **removing silos, enhancing primary care and community-based services**, and **integrating behavioral health and primary care.**
- Built on the CMS and State goals in the Triple AIM
  - Improving Quality of Care
  - Improving Health
  - Reducing Costs

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Performing Provider Systems (PPS)

- Partners include:
  - Hospitals
  - Health Homes
  - Skilled Nursing Facilities
  - Clinics & FQHCs
  - Behavioral Health Providers
  - Home Care Agencies
  - Physicians/Practitioners
  - Other Key Stakeholders

Community health care needs assessment based on multi-stakeholder input and objective data.

Building and implementing a DSRIP Project Plan based upon the needs assessment in alignment with DSRIP strategies.

Meeting and reporting on DSRIP Project Plan process and outcome milestones.

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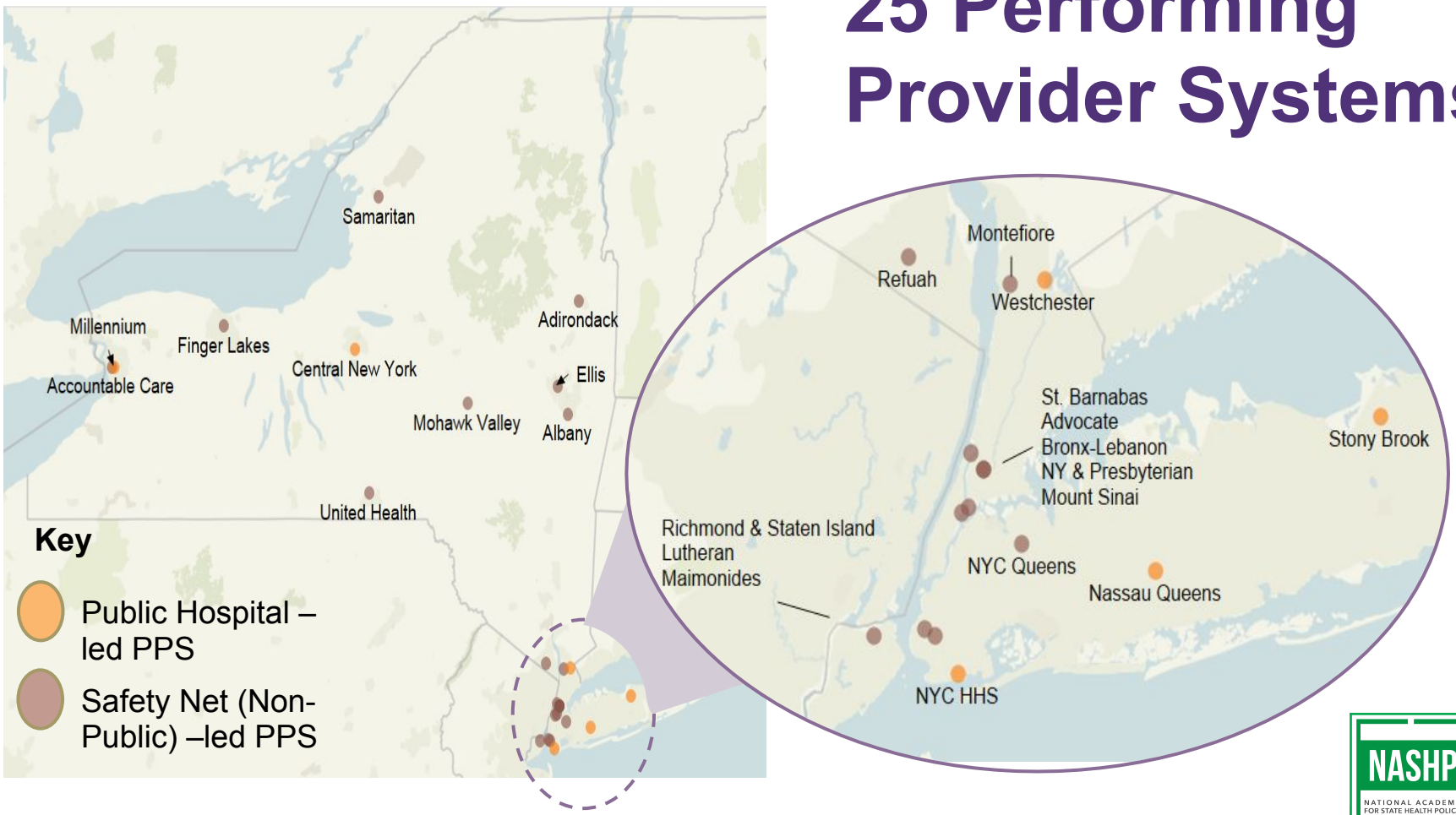
Performing Provider Systems (PPS)

25 Performing Provider Systems



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Data Access in DSRIP

DEAA, Opt-out Process, MAPP, RHIOs, & SHIN-NY

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Process Flow for Release of Medicaid Data

PPS Lead completes DEAA Addendum

PPS Lead allowed to receive PHI data (with restrictions)

Data made available through DOH-CMA secure file transfer

To receive data, PPS Lead needs to work with CMA to set up secure file transfer in their environment

Opt-out process completed

PPS Lead may view DOH Medicaid Data via MAPP (when available

PPS Leads completes Security Affidavit and implements prescribed security controls

PPS Lead allowed to grant access to DOH Medicaid data for remote users within its own organization (but not to downstream partners)

PPS Lead allowed to grant access to DOH Medicaid data to downstream partners

Legend:

Purple Arrow – Path for Accessing in MAPP

Blue Arrow – Path for Accessing Outside MAPP

Data Exchange Application & Agreement (DEAA) Addendum

- In order for a PPS lead to receive permission from the state to access PHI Medicaid data from the State, they must agree to and submit a DEAA Addendum to the State
- PPS submits a Security Assessment to the Department that certifies that they have implemented necessary Security Protocols in order to receive PHI (2FA)
- Once Opt-Out Process (following slide) is complete and additional Security Assessment Affidavits completed, data can be shared with downstream partners by the lead PPS

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Patient Data – Opt Out Process (1)

- NYS is modeling the DSRIP consent process on the Medicare ACO model which is an opt-out model
- Unless member formally opts-out of DSRIP data sharing, they are considered participating in data sharing.
- To “opt-out” means electing NOT to permit the sharing of any PHI and other Medicaid data held by the state with the PPS and its partners.
- The member who “opts-out” will not have his/her Medicaid data shared with the PPS Lead Entity and partners.
- A member can opt-out or opt-in for data sharing at any time.

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Patient Data – Opt Out Process (2)

- To begin the data sharing process, Medicaid has contacted all members by mail and is providing each an opportunity to opt-out of the DSRIP data sharing with the PPS and partners.
- Until this first “opt-out” process cycle is complete, DOH-supplied PHI information cannot be shared with the PPS downstream partners.
- Medicaid will present the opt-out information to new members when they enroll.
- The DSRIP opt-out process only covers DOH Medicaid data that is shared with the PPS.

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Patient Data – Opt Out Letter

- Letter meets federal and state requirements related to PHI and privacy based upon review by NYS DOH, OMH, and OASAS
- Over 6 million letters have been released this summer to Medicaid members
- Medicaid members have 30 days to respond
- A process has been built for finding alternative addresses for returned mail
- The initial Opt-Out process is scheduled for completion end of December 2015

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New York State Health Home Model

Managed Care Organizations (MCOs)

New York State Designated Lead Health Home
Administrative Services, Network Management, HIT Support/Data Exchange

MAP P

RH IO

Health Home Care Management Network Partners (includes former TCM Providers)

Comprehensive Care Management
Care Coordination and Health Promotion
Comprehensive Transitional Care
Individual and Family Support
Referral to Community and Social Support Services
Use of Health Information Technology to Link Services (Electronic Care Management Records)

Access to Required Primary and Specialty Services
(Coordinated with MCO)
Physical Health, Behavioral Health, Substance Use Disorder Services, HIV/AIDS, Housing, Social Services and Supports

NEW YORK STATE | Department of Health | Medicaid Redesign Team

NYS Health Home Consent

- Outreach program fueled by limited claims and encounters *pre-consent*.
- Assertive consent (not opt out) gathered at enrollment.
- One Consent covers physical, mental health and substance use disorder.
- One Consent form covers entire health home network (not one at a time).
- Working with RHIOs to do multiparty consent.

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NYS Health Home Consent

NEW YORK STATE DEPARTMENT OF HEALTH
Medicaid

Health Home Patient Information Sharing Consent

Name of Health Home

By signing this form, you agree to be in the _____ Health Home. To be in a Health Home, health care providers and other people involved in your care need to be able to talk to each other about your care and share your health information with each other to give you better care. While being in a Health Home will help make sure you get the care you need, you will still be able to get health care and health insurance even if you do not sign this form or do not want to be in the Health Home.

The Health Home may get your health information, including your health records, from partners listed at the end of this form and/or from others through a computer system run by the _____, a Regional Health Information Organization (RHIO) and/or a computer system called PSYCKES run by the New York State Office of Mental Health. A RHIO uses a computer system to collect and store your health information, including medical records, from your doctors and health care providers who are part of the RHIO. The RHIO can only share your health information with the people who you say can see or get your health information. PSYCKES is a computer system to collect and store your health treatment from your doctors and health care providers who are part of the Medicaid program.

If you agree and sign this form, the Health Home and the partners listed on this form are allowed to get, see, read and copy, and share with each other, ALL of your health information (including all of your health information the Health Home obtains from the RHIO and/or from PSYCKES) that they need to give you care, manage your care or study your care to make health care better for patients. The health information they may get, see, read, copy and share may be from before and after the date you sign this form, Your health records may have information about illnesses or injuries you had or may have had before; test results, like X-rays or blood tests; and the medicines you are now taking or have taken before. Your health records may also have information on:

1. Alcohol or drug use programs which you are in now or were in before as a patient;
2. Family planning services like birth control and abortion;
3. Inherited diseases;
4. HIV/AIDS;
5. Mental health conditions; and/or
6. Sexually-transmitted diseases (diseases you can get from having sex).

Your health information is private and cannot be given to other people without your permission under New York State and U.S. laws and rules. The partners that can get and see your health information must obey all these laws. They cannot give your information to other people unless you agree or the law says they can give the information to other people. This is true if your health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The partners that use your health information and the Health Home must obey these laws and rules.

Please read all the information on this form before you sign it.

☐ **I AGREE to be in the _____ Health Home and agree that the Health Home can get ALL of my health information from the partners listed at the end of this form and from others through _____ RHIO and/or through PSYCKES to give me care or manage my care,** to check if I am in a health plan and what it covers and to study and make the care of all patients better. I also AGREE that the Health Home and the partners listed at the end of this form may share my health information with each other. I understand this Consent Form takes the place of other Health Home Patient Information Sharing Consent Forms I may have signed before to share my health information. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form (DOH-5058) and giving it to one of the Health Home partners.

Print Name of Patient | Patient Date of Birth

Signature of Patient or Patient's Legal Representative | Date

Print Name of Legal Representative | Relationship of Legal Representative to Patient

NEW YORK STATE DEPARTMENT OF HEALTH
Medicaid

Health Home Patient Information Sharing Consent

Name of Health Home

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The Health Home may get your health information, including your health records, from partners listed at the end of this form and/or from others through a computer system run by the _____, a Regional Health Information Organization (RHIO) and/or a computer system called PSYCKES run by the New York State Office of Mental Health. A RHIO uses a computer system to collect and store your health information, including medical records, from your doctors and health care providers who are part of the RHIO. The RHIO can only share your health information with the people who you say can see or get your health information. PSYCKES is a computer system to collect and store your health treatment from your doctors and health care providers who are part of the Medicaid program.

If you agree and sign this form, the Health Home and the partners listed on this form are allowed to get, see, read and copy, and share with each other, ALL of your health information (including all of your health information the Health Home obtains from the RHIO and/or from PSYCKES) that they need to give you care, manage your care or study your care to make health care better for patients. The health information they may get, see, read, copy and share may be from before and after the date you sign this form, Your health records may have information about illnesses or injuries you had or may have had before; test results, like X-rays or blood tests; and the medicines you are now taking or have taken before. Your health records may also have information on:

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Please read all the information on this form before you sign it.

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Print Name of Patient | Patient Date of Birth

Signature of Patient or Patient's Legal Representative | Date

Print Name of Legal Representative | Relationship of Legal Representative to Patient

_____ **Participating Partners**
Health Home Name

Copy this page as necessary to list all participating partners

Patient Initials | Date

Name of Participating Partner

Name of Participating Partner

Name of Participating Partner

Name of Participating Partner

Name of Participating Partner

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Name of Participating Partner

https://www.health.ny.gov/forms/doh-5055.pdf

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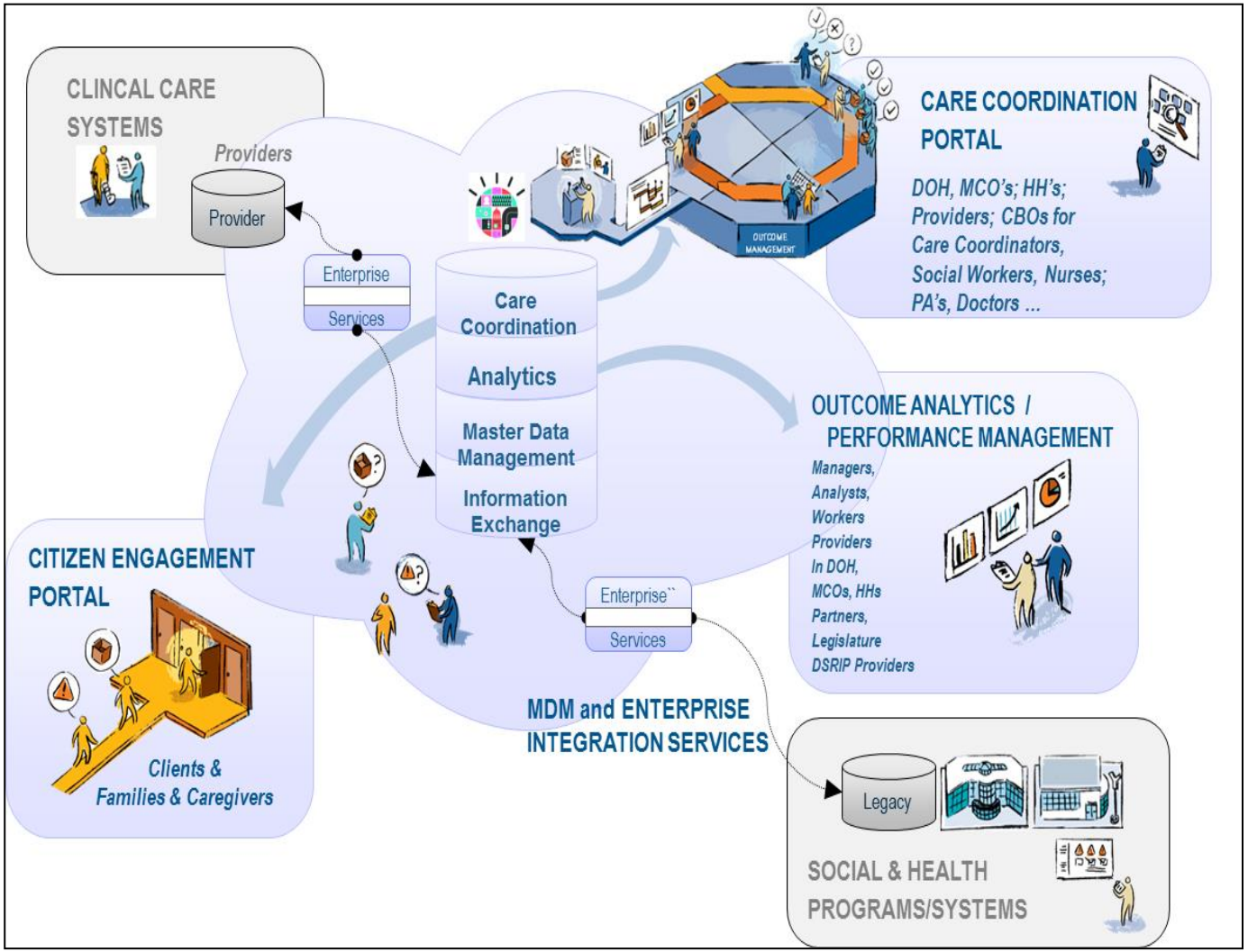
Medicaid Analytics and Performance Portal



MAPP Development

- First stage of MAPP development includes:
  - Moving current Health Home Member Tracking System to a Web-Based Portal.
  - Providing Health Homes, Care Management Agencies and Managed Care Plans access to Medicaid Data Warehouse and Salient analytics to provide additional monitoring and performance management capabilities
  - Developing a Web-based referral tool
- Subsequent stages will include enhanced management capabilities and access to a care management record system (Curam).

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MAPP Development and Performance Management

- MAPP will be a key tool in shifting focus of the program from start up to performance by providing MCOs, Health Homes and care managers access to analytical tools and data to actively manage the program and achieve better outcomes.
- Access to Data and Performance Analytics will be:
  1. Transparent: Plans, Health Homes, Care Mangers and the State all have access to the same performance data
  2. Useful as a Management Tool: Data views will be useful, timely and actionable data
  3. Easily Accessible: Easy to deploy and use without significant training (Dashboard displays of data)

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Regional Health Information Organizations (RHIOs)

- Providing data that is timely, accurate, and easily accessible to support population health analysis and inform treatment decision-making is critical to DSRIP's success. It is therefore critical that PPS providers make clinical data available to other PPS providers by connecting with their **Regional Health Information Organization** (RHIO)
- As of July 1, 2015 the RHIO completed their certification process and have now become **Qualified Entities** (QE).
- QEs are devoted to developing and deploying interoperable health information technology and analytics to facilitate patient-centric care across health settings
- There are 9 QEs in New York State, each storing sharing electronic health information for the providers in a distinct geographic area

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Core Minimum Services

- The QE's will provide a secure environment that protects patient information.
- Patient Record Lookup and Secure Messaging are being implemented on a statewide basis
- There are eight core services that will be provided by each Qualified Entity
- The core services support management of patient identities across Providers, Networks, and Regions
- The core service give Providers access to public health data
- The QE will be able to deliver alerts and results to Providers

Core Minimum Services:

- Patient Record Lookup (Community)
- Patient Record Lookup (Statewide)
- Secure Messaging Direct
- Consent Management
- Notification (Alerts)
- Identity Management & Security
- Provider and Public Health Clinical Viewer
- Public Health Integration
- Result Delivery

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QE Minimum Core Services & Additional Integration Services Currently Provided

	Patient Portal	Provider Portal	Patient Care Summary/ Health Record/ ADT Info	Data Analytics	Notification/Alert	Direct Messaging	Population Health Management	Public Health Reporting/ Syndromic Surveillance	Medical history (Medication allergy & problem list)	Lab info	Radiology info	Transcription	Claims History
Bronx	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A
eHNLI	N	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N/A	N/A
HealtheConnections	N	Y	Y	N	Y	Y	N	Y	Y	Y	Y	N/A	N/A
HealtheLink	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N/A
Healthix\ BHIX	N[1]	Y	Y	N	Y	Y	N	N	Y	Y	Y	N/A	N/A
HIXNY	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Interboro	N	Y	Y	N	Y	Y	N	N	Y	Y	Y	N/A	N/A
Rochester	N[2]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	N/A
HealthLinkNY	N	Y	Y	Y	Y	Y	Y	N/A	Y	Y	Y	N/A	N/A

1 – Healthix currently does not have a patient portal exposed to the patients, but it may have the capability.

2 – Rochester Patient portal does not provide link to patient medical information. The portal described on their website is not a patient portal as defined by Meaningful Use. It may have the capability to provide a patient portal as defined by Meaningful Use.

Legend	
N	Not provided by RHIO
Y	Provided by RHIO
N/A	Information Not Available

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The Advantages of Data Integration through QEs

- QEs will be able to initiate the integration process as soon as data dictionaries for the Medicaid Claims Database are shared
- Since clinical data is shared by multiple PPSs, the QEs will be able to produce meaningful comprehensive and cross-PPS analytics using the integrated data.
- Integrated data will be very useful for:
  1. Data Analytics
  2. Population Health Management
  3. Understanding cost and effectiveness of treatments
  4. Measuring DSRIP projects' success

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Statewide Health Information Network of New York (SHIN-NY)

- The SHIN-NY is a "network of networks" that links New York's nine QEs throughout the State.
- With patient consent, the QE allows those records to be accessed securely by other healthcare providers
- As part of the SHIN-NY, QEs will be able to exchange records between each other, creating a statewide network of health information

This "network of networks" is the keystone of the State's strategy of safely and securely sharing accurate and useful health data through the DSRIP Program

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Sharing Data Across Systems – Policy and Operational Considerations

- Legal access to data
- Consent requirements (clinical)
- Security requirements (Medicaid > QE Policy Standards)
- Security audits for non-certified entities
- Analytic standards (comparative quality measures across PPSs)
- Data governance (MDM algorithm, data access, etc.)
- Data cleansing/validation
- Data storage and system processing optimization
- Initial/Ongoing costs and funding mechanisms
- Sustainability Models beyond DSRIP/HITECH
- Compliance with current and future regulations

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Patient Consent & Data Security

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Patient Consent

- Prior to going through the Opt-out process for patient consent, each PPS will have to determine how they intend to access the Medicaid data provided by the New York State DOH
  - If the PPS decides they don't want to store the data within their organization they will use the MAPP tool to access Member roster and claims extract files for their attributed population
  - If however, a PPS does want to store the Medicaid data of their attributed members within their organization they will have to follow several steps to ensure the security of that data because the Medicaid data files contain PHI
- The PPS lead entity will have to have a secure server where they can store the files and they will need to designate two tech savvy users with accounts on the server who will be able to retrieve and decrypt the DOH provided data that contains the PHI.
- The two users accessing the PHI will need IAL 3 which includes in-person identity proofing using a government issued ID along with two factor authentication tokens (2FA tokens)

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Data Security through Two-Factor Authorization

- 2FA (Two-Factor Authorization) will be implemented by August 2015.
- The initial 2FA implementation will require users to have a NYS DMV-issued identification.
- 2FA tokens are a state approved form of identification that is usually something you have, that can only be unlocked by something you know or something you are.
  - For example a certificate (something you have) is unlocked by a passcode (something you know) and the combination of the two provides the user access to the protected information

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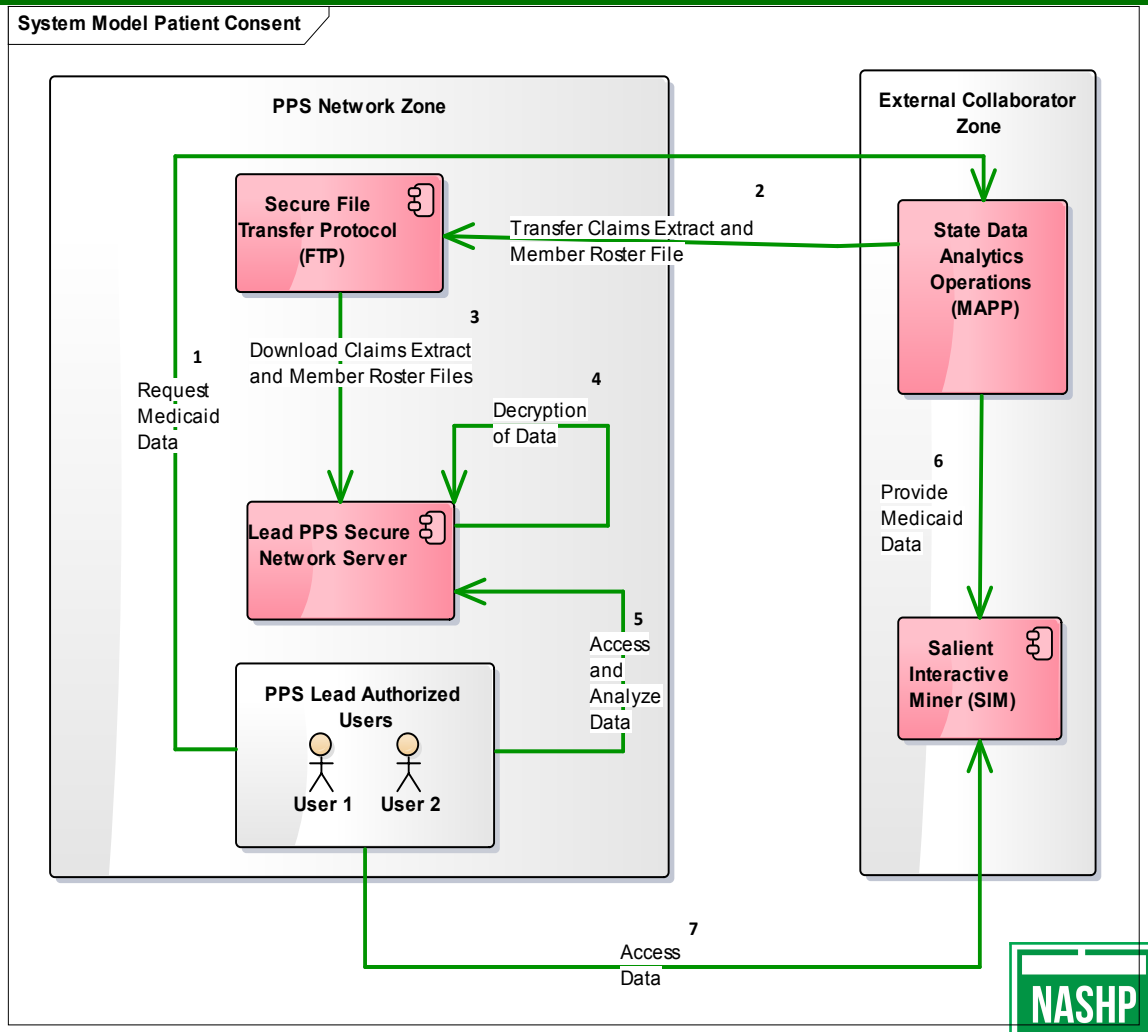
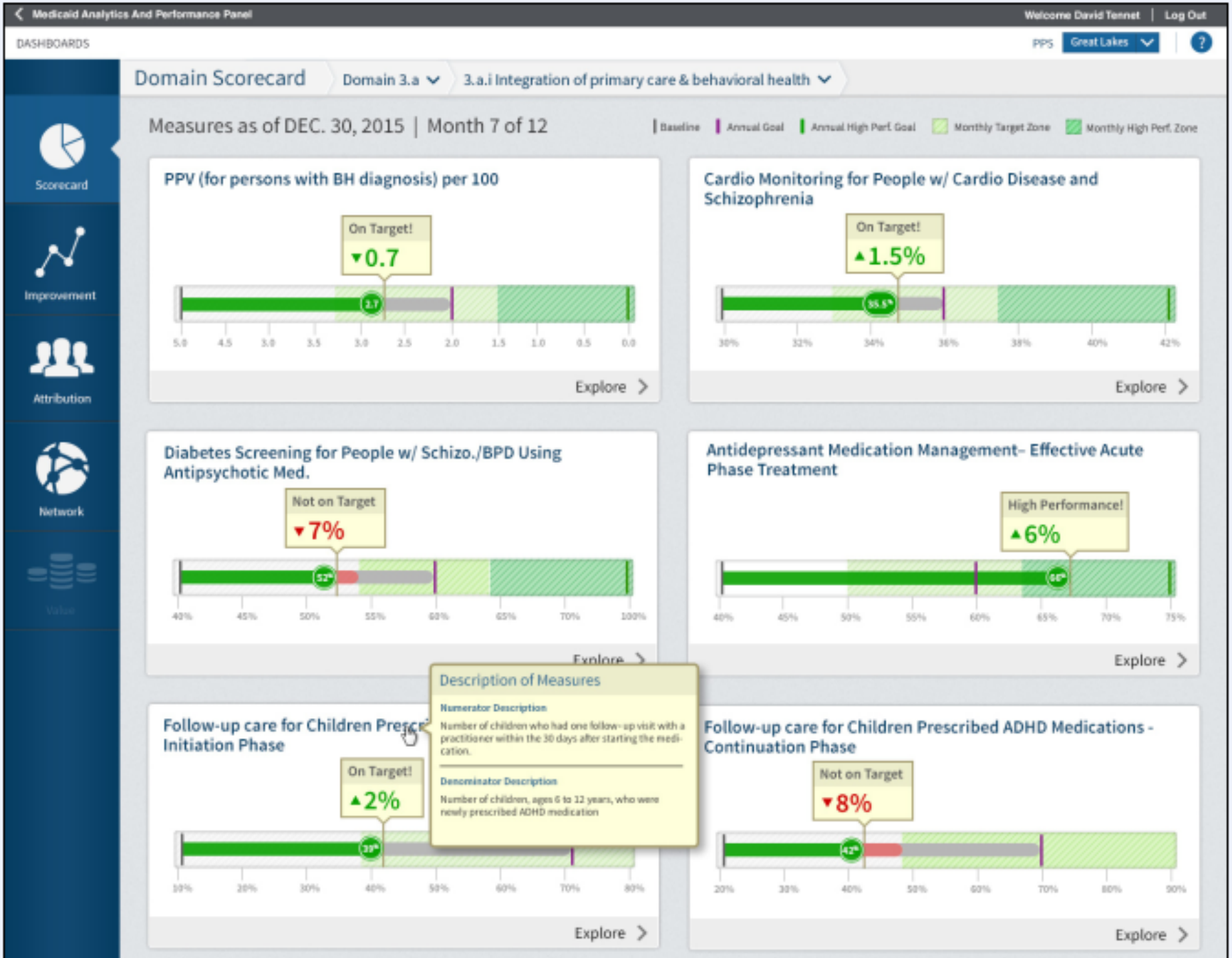
Patient Consent - Process

The process flow for the file transfer is as follows and outlined in the model below:

1. The PPS lead entity requests the member roster file and claims extract file from the MAPP tool.
2. The MAPP tool will send an encrypted file containing the member roster and claims extract to a secure FTP.
3. Once the file is in the FTP the authorized and identified users will log in and download the file to the lead PPS secure server.
4. The two identified users will then decrypt the file to unlock the data for PPS use.
5. The two identified users access and analyze the data.




Medicaid Analytics And Performance Panel
Welcome David Tennet | Log Out
DASHBOARDS
PPS
Great Lakes
Domain Scorecard
Scorecard
Improvement
Attribution
Network
Value
Overal Project Progress
Domain 1
60/70
Items Approved
View
System Transformation
Domain 2 A-C
3/10
Measures On Track
View Projects
Behavior Health
Domain 3 A
5/9
Measures On Track
Hide Projects
Diabetes
Domain 3 C
3/10
Measures On Track
View Projects
3.a.i
Integration of primary care ...
5/9
3.a.ii
Behavioral health community...
5/9
3.a.iii
Implementation of evidence...
5/9
3.a.iv
Development of withdrawal ...
5/9
3.a.v
Behavioral Interventions...
5/9
View Selected
Asthma
Domain 3 D
8/9
Measures On Track
View Projects
Perinatal
Domain 3 F
4/6
Measures On Track
View Projects
Palliative Care
Domain 3 G
1/6
Measures On Track
View Projects
Population Health
Domain 4
5/10
Measures On Track
View Projects


Medicaid Analytics And Performance Panel
Welcome David Tennet | Log Out
DASHBOARDS
PPS
Great Lakes
Domain Scorecard
Domain 3.a
3.a.i Integration of primary care & behavioral health
Scorecard
Improvement
Attribution
Network
Value
Measures as of DEC. 30, 2015 | Month 7 of 12
Baseline
Annual Goal
Annual High Perf. Goal
Monthly Target Zone
Monthly High Perf. Zone
PPV (for persons with BH diagnosis) per 100
On Target!
▼0.7
Explore
Cardio Monitoring for People w/ Cardio Disease and Schizophrenia
On Target!
▲1.5%
Explore
Diabetes Screening for People w/ Schizo./BPD Using Antipsychotic Med.
Not on Target
▼7%
Explore
Antidepressant Medication Management– Effective Acute Phase Treatment
High Performance!
▲6%
Explore
Follow-up care for Children Prescr
Initiation Phase
On Target!
▲2%
Explore
Description of Measures
Numerator Description
Number of children who had one follow-up visit with a practitioner within the 30 days after starting the medication.
Denominator Description
Number of children, ages 6 to 12 years, who were newly prescribed ADHD medication
Follow-up care for Children Prescribed ADHD Medications - Continuation Phase
Not on Target
▼8%
Explore

Domain Scorecard

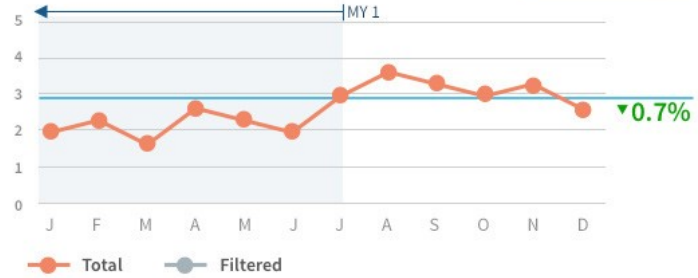
Domain 3.a > 3.a.i Integration of primary care & behavioral health > PPV (for persons w/ BH diagnosis) per 100

Measures as of DEC. 30, 2015

PPV (for persons with BH diagnosis) per 100

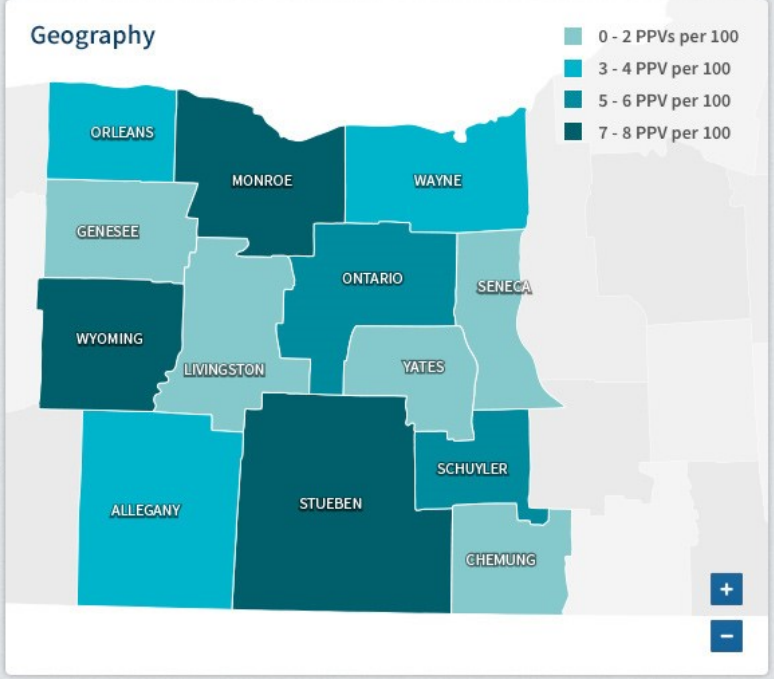
Trend

Range: Past 12 Months



Gender: All | Age Group: All | CRG: All

Geography



Score Distribution

Show: Bottom 10

PCP ▼ — click PCP name or member count to view details

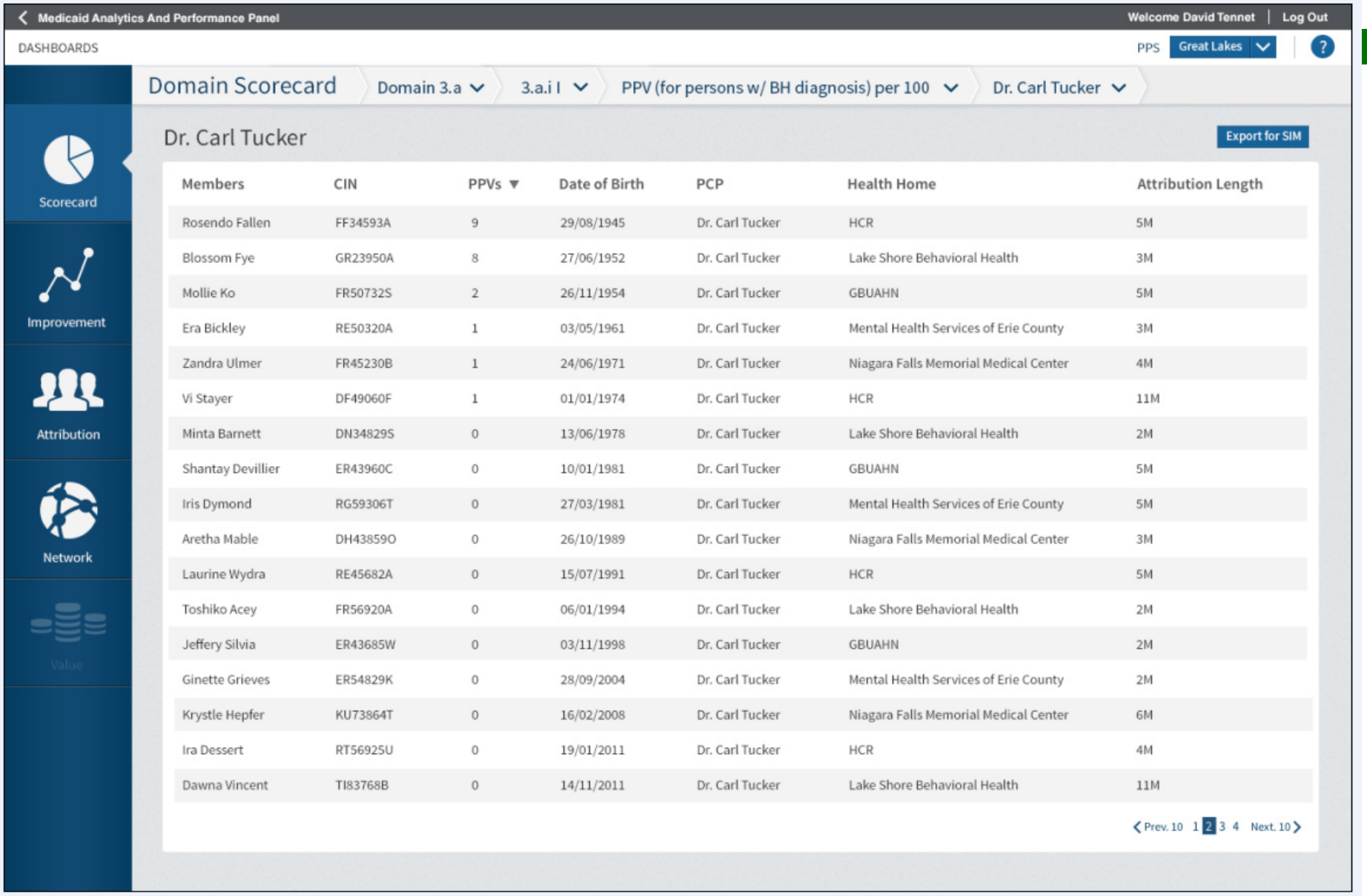
PCP
PPS
PPS Hub
HH
HH Care Management Agency
MCO

PCP	# Members	PPV (for persons with BH diagnosis)
	117	23
	45	12
	5	9
	16	8
	42	6
	54	4
Dr. Otilia Rosel	21	3
Dr. Earle Castro	19	2
Dr. Erlinda Visser	23	2
Dr. Brandee Vaughn	12	2

Export Data

Prev. 10 1 2 3 4 Next. 10

State Solution Performance Dashboards
→ …to Member detail



Questions?

DSRIP e-mail:
dsrip@health.state.ny.us

Question and Answer

Please use the chat box at the bottom of your screen to ask a question.

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Thank you

- Please complete our evaluation on the next slide.

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